

Patient Registration

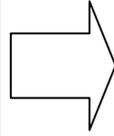
Please complete the following confidential information

Start Here for YOU

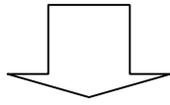
Date			
Last Name		First	
Prefers to be called by			
Address			
City		State	Zip Code
Home No:		Work No:	
Cell No:		E-mail:	
Male	Female		
Married	Single	Divorced	Widowed
Birthday		Age	
Social Security No.			

Start Here for CHILD

Date			
Last Name		First	
Prefers to be called by			
Address			
City		State	Zip Code
Home No.		Addtl No.	
Cell No:			
Male	Female		School
Birthday		Age	Grade
Social Security No.			

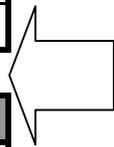


Primary Dental Insurance	
Insurance Company:	
Ins Co. Address	
City, State Zip	
Group No. / I.D. No.	
Ins. Co. Phone Number	
Employer Name	
Subscriber's Name	
Social Security No.	
Date of Birth:	
Relationship to Patient: <i>Self Spouse Child Other</i>	



Patient Information (If not the responsible party)		
Name		
Relationship to Patient		
Address		
City	State	Zip
Home No	Cell No.	
Employer		
Address:		
Work No.		

Person Financially Responsible for Account		
Name		
Relationship to Patient		
Address		
City	State	Zip
Home No.	Cell No.	
E-mail Address:		
Employer		
Address		
Work No.		



Person to contact for Emergency		
Name:		
Relationship		
Address		
City	State	Zip
Home No.		
Cell No.		
Work No.		

Getting To Know You	
<i>Is another family member at patient?</i>	
Name:	
Relationship:	
<i>How were you Referred to our office?</i>	

Dental History

PATIENT NAME: _____	DATE: _____
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What is the reason for your visit today? _____

Previous Dentist Name _____

Address _____ *State* _____ *Zip* _____

Telephone _____ *Fax* _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

How often do you have dental examinations? Every 6 months Once a year Other _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric toothbrush, toothpick, etc) _____

Do you have any dental problems now? *Yes No If yes, describe:* _____

	Are any of your teeth sensitive to:		Have you ever had:
<input type="checkbox"/>	Hot or Cold	<input type="checkbox"/>	Orthodontic treatment
<input type="checkbox"/>	Sweets	<input type="checkbox"/>	Oral Surgery
<input type="checkbox"/>	Biting or Chewing	<input type="checkbox"/>	Periodontal treatment
<input type="checkbox"/>	Any mouth odors or bad tastes?	<input type="checkbox"/>	Your bite adjusted
<input type="checkbox"/>	Frequently get cold sores, blisters or any other lesions?	<input type="checkbox"/>	A mouth guard or bite plate
<input type="checkbox"/>	Gums bleed or hurt?	<input type="checkbox"/>	A serious injury to the mouth or head?
Y / N	Have your parents experienced gum disease or tooth loss?		<i>If so, please describe:</i>
Y / N	Have you noticed any loose teeth or change in your bite?		Have you experienced:
Y / N	Does food tend to become caught between your teeth?	<input type="checkbox"/>	Clicking or popping of the jaw
	<i>If yes, where?</i>	<input type="checkbox"/>	Pain (joint, ear, side of face)
		<input type="checkbox"/>	Difficulty in opening or closing the mouth
	Do You:	<input type="checkbox"/>	Difficulty in chewing on either side of the mouth
<input type="checkbox"/>	Clench or grind your teeth while awake or asleep?	<input type="checkbox"/>	Headaches, neck aches or shoulder aches
<input type="checkbox"/>	Bite your lips or cheeks regularly?	<input type="checkbox"/>	Sore muscles (neck, shoulder)
<input type="checkbox"/>	Hold foreign objects with your teeth?		
<input type="checkbox"/>	Mouth breathe while asleep or awake?		Are you satisfied with your teeth's appearance?
<input type="checkbox"/>	Have tired jaws, especially in the morning?	Y / N	Would you like to keep all of your teeth all your life?
<input type="checkbox"/>	Smoke / chew tobacco or use other tobacco products?	Y / N	Do you feel nervous about having dental treatment?
<input type="checkbox"/>	Snore, been told you snore, or have any sleeping disorders?		<i>If yes, what is your biggest concern?</i>

Have you ever had an upsetting dental experience? If yes, please describe: _____

Is there anything else about having dental treatment that you would like us to know? _____

Medical Form

PATIENT NAME: _____

DATE : _____

If you answered **yes** please explain:

- Are you under a physician's care now? Yes No _____
- Have you ever been hospitalized or had a major operation? Yes No _____
- Have you ever had a serious head or neck injury? Yes No _____
- Are you taking any medications, pills or drugs? Yes No _____
- Have you been diagnosed with a sleep disorder or apnea? Yes No _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you Pregnant / trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had any of the following?

<input type="checkbox"/> AIDS/HIV positive	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heat Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker*	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

* Condition may require medication

Have you ever had any serious illness not listed above? YES NO _____

If YES please explain

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

Today's Date

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental and/or medical needs.
(Name of Patient)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give my consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % late charges (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
6. I give my permission for my or my dependents diagnostic and treatment records to be used for purposes of research, education, or publication in professional journals.

Patient's or Guardian's Signature

Relationship to Patient

Today's Date

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I, _____, have received and/or reviewed a copy of the
(Patient's Name)
Notice of the Privacy Practices for the office of ***Sherman Oaks Dental & Dental Sleep Medicine of Illinois.***

Please sign and date: _____ Date: _____
(parent signature if a minor)

OPTING OUT:

- I **do not** want appointment reminder messages left on my home answering system; I understand that the office may charge me should I fail to keep my appointment.
 - I **do not** want appointment reminder messages left at my place of employment; I understand that the office may charge me should I fail to keep my appointment.
 - I **do not** want appointment reminders by e-mail.
 - I **do not** wish my protected health care information to be released to the following persons _____ .
(give name and address)
 - I **decline** to sign the Acknowledgement.
-

OFFICE USE:

The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons:

SUPPLEMENTARY HEALTH QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Have there been any changes in your medical history since your last visit? Yes _____ No _____

Has anyone ever commented or told you that you snore? Yes _____ No _____

If yes, how often: rarely _____ sometimes _____ often _____ most nights _____

Has anyone ever heard you stop breathing or choking at night? Yes _____ No _____

On an energy level, 10 being the most active and energetic. How would you rate yourself on most days?

(Circle one) 1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Have you been diagnosed with a sleep disorder? Yes _____ No _____

If yes, have you been prescribed CPAP therapy? Yes _____ No _____

If yes, do you wear your CPAP and how often?
 every night _____ most nights _____ couple nights per week _____ never _____

Do you experience headaches or migraines regularly? Yes _____ No _____

If yes, how often: rarely _____ sometimes _____ often _____

What medications to you take? _____

Do you knowingly grind your teeth at night or have been told by a dentist that you may be grinding?

If yes, do you wear a night guard? Yes _____ No _____

Have you ever had a problem with your TMJ /TMD jaw joint? Yes _____ No _____

Are you happy with the appearance of your teeth? Yes _____ No _____

If no, are you dissatisfied with: (circle all that apply)

Color _____ Looks of previous fillings / crowns _____

Shape _____ Condition / Level of gums _____

Spacing _____ Other _____

Crowding _____

Are you interested in knowing more about our home whitening system? Yes _____ No _____

Have you noticed a bad taste/odor in your mouth on a frequent basis? Yes _____ No _____

Are you regularly involved in sports? Yes _____ No _____

List sports? _____

Would you like to know more about our custom athletic sports guards for you or a family member?

Yes _____ No _____

Are you interested in knowing about permanent tooth replacement? Yes _____ No _____

or implant tooth replacement? Yes _____ No _____